



**Kansas Medical Assistance Program**

P O Box 3571  
Topeka, KS 66601-3571  
Provider 1-800-933-6593  
Beneficiary 1-800-766-9012

**Prior Authorization for Limit Override and Non-Preferred Proton Pump Inhibitors**

<b>Preferred</b>	<b>Non-Preferred, Prior Authorization Required</b>
Prilosec® (omeprazole) Protonix® (pantoprazole)	AcipHex® (rabeprazole) AcipHex® Sprinkles (rabeprazole) Dexilant® (dexlansoprazole) Esomeprazole strontium® (esomeprazole strontium) Nexium® (esomeprazole) Nexium® Suspension (esomeprazole) Prevacid® (lansoprazole) Prevacid SoluTab® (lansoprazole) Prilosec® Packets (omeprazole)

**Beneficiary Information**

Name: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Pharmacy Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Requested Drug: \_\_\_\_\_ NDC: \_\_\_\_\_

**Prescriber Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Clinical Prior Authorization Information (required if requesting limitation override)**

Please provide the diagnosis for which the PPI is being prescribed (ICD code alone is not adequate): \_\_\_\_\_

Please provide PPI and dose requested: \_\_\_\_\_

Does the beneficiary have a history of a gastric ulcer?  Yes  No

If yes, please specify cause of ulcer (example, NSAID usage, existing condition): \_\_\_\_\_

Is the beneficiary currently taking NSAIDs?  Yes  No

If yes, please provide current NSAID dose: \_\_\_\_\_



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**PDL Non-Preferred Prior Authorization Information (required for non-preferred agents)**

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Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

- Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: \_\_\_\_\_  
\_\_\_\_\_
- Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: \_\_\_\_\_  
\_\_\_\_\_
- An appropriate formulation or indication is not available as a preferred drug.** Please specify which formulation or indication is needed and information supporting the need: \_\_\_\_\_  
\_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.**

**This form will be returned unprocessed if it is not completed in its entirety.**